STRATEGIES FOR PRIMARY CARE*

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THE Congress of the United States approaches health legislation in terms of three main problem areas: cost, availability, and quality. Whenever the Congress develops legislation, it tries to influence at least one of these three areas. At present the major problem is unquestionably that of cost. During the past two decades the costs of health care have increased at a rate as much as twice the rate of increase of the consumer price index. The result of this sustained high rate increase is now being felt. From now on the problem of cost will be the single most important influence on health legislation.

Two important areas within the area of manpower legislation are relevant to the problem of cost.

Regarding the problem of aggregate numbers of physicians, it is now generally understood in the Congress and by the administration that a supply of physicians in excess of an adequate supply, whatever that is, is inflationary. The experience of the prepaid group practices, including the Kaiser program, suggests that a minimum adequate supply may be in the range of 200 physicians per 100,000 population.

Since the percentage of the gross national product that a society will spend for health care is correlated rather closely with the physician-to-population ratio, the intent, in terms of national policy, should be a supply not greatly in excess of the minimum adequate supply. In my opinion we now have a supply of physicians far in excess of a minimum adequate supply. For this reason, it seems that federal policy probably will not demand a further increase in the number of graduates of our medical schools.

The second point with respect to cost is whether we can afford physicians. This is a problem that Dr. Milton Terris really did not address. Physicians in the United States have an average income of $55,000 a year. The country will soon have 400,000 or 450,000 physicians. Can we really afford to maintain

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that many people at that high an income? The answer may well be that we cannot. This point, which has not been directly considered this year, may well be an issue in the next renewal of health-manpower legislation in 1980. Instead of expanding our medical schools, the Congress may want to contract them. At that time we may want to move strongly toward the training and utilization of nurse-clinicians, physicians' assistants, expanded duty dental auxiliaries, and similar health professionals, simply because these persons do not earn $55,000 each per year.

The manpower legislation, then, does address the cost problem. It does not, of course, attack this problem as directly as does planning legislation, health maintenance organization (HMO) legislation, or national health-insurance legislation. The problem of availability and accessibility of care is the area that manpower legislation addresses most directly.

The third problem area is that of quality. One provision of the manpower legislation addresses the problem of quality. This provision deals with the problem of foreign medical graduates (FMGs). In the past several years approximately 45% of new physicians in the United States have been graduates of foreign medical schools. In more than a dozen states the majority of newly licensed physicians have been graduates of foreign schools. The quality of medical care provided by foreign graduates simply cannot equal that of graduates of schools in the United States. This is especially true since quality care requires not only biomedical scientific competence but the ability to communicate with patients, to understand their cultural milieu.

The FMG issue, of course, raises questions beyond that of the quality of care provided by FMGs. In recent years thousands of physicians trained in the developing nations have come to the United States. Questions of foreign policy arise when the wealthiest nation in the world imports large numbers of physicians from the third world. It is now probably that a new federal policy will be adopted in this area. This policy will require all FMGs coming to the United States to pass Parts I and II of the national boards. It will also return the Exchange Visitor (J.-Visa) program to its original purpose in the period that followed World War II. At that time the program brought people to the United States to be trained for positions abroad, and then ensured that they returned home to provide better services that, presumably, they had been trained to provide. The new policy will insure that such persons are not imported and retained in the United States in large numbers.

Returning to the most important problem that manpower legislation can affect, the problem of availability and accessibility of care, the major focus

here is on primary care. In this area there is now good over-all agreement on the direction of federal policy. Residual disagreements have to do with particular nuances or approaches to the legislation, and specific details of programs. However, in terms of over-all theme and broad program initiatives, there is good general agreement among the key officials in the House of Representatives, the Senate, and the administration.

In this area it is possible to describe a program that may well be adopted. It is generally agreed that 50% of our new physicians should be in primary care. Primary-care specialties include family practice, primary internal medicine, and primary pediatrics. The number of physicians in primary internal medicine and primary pediatrics is the aggregate number of internists and pediatricians minus the number of physicians in those specialties who are in subspecialties. There is general agreement, at the federal level at least, that a cardiologist is not a primary physician and that a pediatric hematologist is not a primary physician. Thus, the number of first-year residents in family practice, internal medicine, and pediatrics cannot simply be included when calculating the percentage of residents in primary care. The product at the end of the fourth or fifth, the final fellowship year; must be counted in order to determine the real number in primary care.

If our goal is to train 50% of our new doctors in the primary-care specialties, what techniques can be used to achieve this? The Subcommittee on Health of the House of Representatives adopted the program supported by the Association of American Medical Colleges. This program would operate by setting over-all limits through the Coordinating Council on Medical Education (CCME). This proposal was opposed by the American Medical Association. It was deleted in a vote on the floor of the House last summer.

Since that time the administration has presented its proposal, which involves not national aggregates, but a school-by-school approach. It would require each school to have 35%, 40%, and, finally, 50% of its filled affiliated residencies in the three primary-care specialties. This approach would thus be based on 114 minisystems.

The third approach is included in the bill which has been reported from the Subcommittee on Health of the Senate. This program is similar to that supported by the Association of American Medical Colleges. The difference, however, is that instead of directly involving the CCME as such, a council would be appointed directly by the secretary of the Department of Health, Education, and Welfare. The secretary is required to appoint individuals so that the group would resemble the current membership of the CCME. The

subcommittee prefers a council of individuals selected from medical schools, private medical practice, hospitals, and non-physician health personnel in the public sector to one wholly in the private sector. This council would determine the percentages of positions in the various specialties and allocate these positions to training programs throughout the country.

There is general agreement at the federal level that there is a need for a regulatory program to insure that 50% or more of new physicians enter the primary-care specialties. The disagreement concerns the mechanism for achieving this goal. The disagreement can be worked out; accommodation will be reached.

The second important area that manpower legislation can affect concerns not training but actual practice. This is the question of how to secure physicians for rural and inner-city areas. The agreement appears to be that the National Health Service Corps offers the right approach. Again, there is general agreement among the House, the Senate, and the administration.

There are a number of reasons why individuals do not go voluntarily to rural or inner-city areas. These reasons include economic status, sociocultural status, educational systems for children, spouse's preference, and others. Because of these factors there is no reason to believe that we are going to get large numbers of physicians in these areas on a purely voluntary basis.

The period in a physician's career when he or she is most amenable to a financial incentive is when he is a medical student. This, of course, is the traditional approach used by the military in the Reserve Officers Training Corps scholarship program. This is the program that the military, with the exploration of the selective draft, is now using to secure physicians. It is agreed that this kind of program should be expanded.

The Senate committee believes that this is the most important of all the various health-manpower programs, and therefore it should have funding priority among all manpower programs. The administration believes that individuals who are willing to serve should receive, in addition to scholarship support while they are in school, some preference for admission to medical school. Again, there are differences on nuances and details, but there is general agreement as to the scope of the program.

In conclusion, the basic health-manpower program will focus on the problems of availability and accessibility. We shall probably see programs which will insure that 50% of new physicians enter the primary-care specialties and that a significant number of physicians are available for assignment to rural and inner-city areas.

These two programs are not, of course, the solution to all our problems in this area. The Congress has looked particularly at the problems of financing which Richard A. Berman will address. Questions of financing will certainly be important in national health-insurance legislation. There will also be the service-reorganization programs: ambulatory care centers; linkages, either in the form of HMOs or Area Health Education Centers; and programs for the training of physicians' assistants and nurse-clinicians. A whole series of programs will be tried and will contribute to an over-all effective solution to our present problems. But the keys right now, certainly from a federal point of view, are changes in residency training and expansion of the National Health Service Corps.